



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$4,000 Person/\$8,000 Family - Embedded	None
<b>Co-insurance</b>	50% Person/50% Family	None
<b>Annual Out-of-Pocket Maximum</b>	\$9,300 Person/\$18,600 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	\$40 copay	First 3 PCP or MH/SA Visits Covered in Full
<b>Specialist Office Visits</b>	\$90 copay	None
<b>Preventive &amp; Well Care Services</b>		
Well Child Care & Immunizations Adult Annual Physical (One per Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy /Sigmoidoscopy Screening Bone Density Tests	Covered in Full. For a full list of covered preventive care services, visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
<b>Diagnostic Laboratory Services</b>	PCP: \$40 copay/Spec: \$90 copay	None
<b>Diagnostic X-ray</b>	PCP: \$40 copay/Spec: \$90 copay	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: 50% coinsurance*/Free-Stnd: 50% coinsurance* \$50 copay	Prior authorization is required for some services
<b>Rehabilitative Services (PT/OT/ST)</b>		30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
<b>Allergy Services</b>	\$90 copay	None
<b>Chemotherapy Visit</b>	\$90 copay	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	50% coinsurance*	Prior authorization is required for some services
<b>Surgical Services</b>	50% coinsurance*	Prior authorization is required for some services
<b>Inpatient Physical Rehabilitation</b>	50% coinsurance*	None
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (OT/ST)</b>	50% coinsurance*	30 combined PT/OT/ST visits per year.
<b>Hospital Rehab Services (PT)</b>	\$50 copay	30 combined PT/OT/ST visits per year.
<b>Diagnostic Laboratory Services</b>	50% coinsurance*	None
<b>Diagnostic X-ray</b>	50% coinsurance*	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs)</b>	50% coinsurance*	Prior authorization is required for some services
<b>Ambulatory/Outpatient Surgery</b>	50% coinsurance*	Prior authorization is required for some services
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	\$500 copay*	None
<b>Urgent Care Centers</b>	\$100 copay	None
<b>Ambulance (Emergency Medical Transportation)</b>	\$100 copay	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	\$40 copay	None
<b>Maternity – Physician Delivery</b>	50% coinsurance*	None
<b>Maternity – Inpatient Hospital Services</b>	50% coinsurance*	None

	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
Mental Health Inpatient Hospital	50% coinsurance*	None
Mental Health Outpatient	\$40 copay	First 3 PCP or MH/SA Visits Covered in Full
<b>Substance Use Disorder Inpatient Hospital</b>		
Substance Use Disorder Inpatient Hospital	50% coinsurance*	None
Substance Use Disorder Outpatient	\$40 copay	First 3 PCP or MH/SA Visits Covered in Full
Residential Treatment	50% coinsurance*	None
<b>Other Services</b>		
Physician Administered Drugs	50% coinsurance*	None
Skilled Nursing Facility	50% coinsurance*	None
Home Health Care	50% coinsurance*	None
Hospice	50% coinsurance*	None
Durable Medical Equipment	50% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	50% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	\$50 copay	No visit limit for Chiropractic Care.
Acupuncture	Not covered	None
<b>Prescription Drug Coverage</b>		
Tier 1	30 day supply: \$20 copay/90 day supply: \$50 copay	None
Tier 2	30 day supply: \$70 copay*/90 day supply: \$175 copay*	Prior authorization is required for some prescriptions
Tier 3	50% coinsurance*	Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	Rx Brand - \$500 individual / \$1,000 family	None
Prescription Out-of-Pocket Maximum	\$1,500 Person/\$3,000 Family - Embedded	None
<b>Vision Care</b>		
Adult Vision Care	Not covered	None
Pediatric Vision Care	\$20 copay	One eye exam per year to age 21
<b>Other Plan Features</b>		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	Not covered	None
Visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage (COC), Schedule, and any applicable Rider(s), your COC, Schedule, and Rider(s) will be controlling. For plan details, please call 1-800-TALK-MVP (825-5687), or visit [mvphealthcare.com](http://mvphealthcare.com).

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